Sandwell and West Birmingham Hospitals NHS
NHS Trust

AUDIT & RISK MANAGEMENT COMMITTEE MEETING MINUTES

Venue: Meeting via WebEx **Date**: 6th May 2021, 15:30 – 17:00

Members:

Mrs L Writtle, Non-Executive Director & Chair	(LW)
Mr M Hoare, Non-Executive Director	(MH)
Mr H Kang, Non-Executive Director	(HK)
Mr M Laverty, Non-Executive Director	(ML)
Dr K Thomas, Non-Executive Director	(KT)

In Attendance:

Mr M Gennard, RSM	(MG)
Mrs D McLannahan, Chief Finance Officer	(DM)
Mr D Baker, Dir. of Partnerships & Innovation	(DB)
Mr M Stocks, Grant Thornton	(MS)
Mr A Hussain, RSM	(AH)
Mr B Vaughan, RSM	(BV)
Ms K Dhami, Director of Governance	(KD)
Ms S Rudd, Assoc. Director of Governance	(SR)
Mr C Higgins, Assoc. Director of Finance	(CH)
Mr S Sheppard, Deputy Director of Finance	(SS)
Mr Z Francis, Grant Thornton	(ZF)

Apologies:

Cllr. W Zaffar, Non-Executive Director	(WZ)

1. Introductions [for the purpose of voice recording].	**Verbal**
The Committee members introduced themselves for the purpose of the meeting recording.	
2. Welcome and apologies for absence	**Verbal**
Apologies were received from Cllr. Waseem Zaffar.	
3. Minutes of the previous meeting: 4th February 2021	**AR (05/21) 001**
The minutes of the meeting held on 4th February 2021 were reviewed and were **ACCEPTED** as a true and accurate record.	
4. Matters and actions arising from previous meetings	**AR (05/21) 002**

An update of matters and actions arising from the previous meeting were provided as follows:

- *AR (02/21) 002 - Provide an update on assessing Committee effectiveness at the next meeting.*
  - LW and KD had acknowledged that changes would be introduced. LW reported she would be meeting new Trust Board Chair Sir David Nicholson to discuss. To be discussed at the June 2021 meeting.

- *AR (02/21) 003 - Provide assurance that sufficient capacity and capability around risk is present in the Trust. Do clinical teams and leaders need development support?*
  - KD expressed the view that, in terms of the Trust's response to risk, there was more work to be done in the clinical groups and the corporate directorates. Customised training had been provided with varied rates of take-up.

- There had been changes in the corporate team including the appointment of a new Head of Risk and Patient Safety, with more changes expected. KD offered to bring a paper to the next meeting to further explain risk management activity and staffing.

- *AR (02/21) 004 – AH to Provide KD with the contact details of a Trust who use Safeguard well.*
  - KD reported that contact details had been provided and the Trust had been in touch. Similar problems with Safeguard had been experienced.
  - KD reported that a 'task and finish' group had been established and an external expert had been utilised.
- *AR (02/21) 007 - Report actual STWs to the Committee for confirm and challenge by members.*
  - DMc reported that there had been a large number of STWs coinciding with financial year end. She expressed uncertainty that the process was working effectively. DMc stated that each one was forwarded to her for sign-off and proper justification was often difficult to see.
  - DMc stated that she had spoken with the Director of Procurement about reviewing the process to ensure it was working as it should. Reporting could commence in the governance pack from the next meeting onwards if the Committee considered it valuable.
  - Internal audit expressed the view that extreme cases could be reported. LW expressed the view that the scale of the problem would be useful for the Committee to understand. DMc offered to investigate the process and report back to the June 2021 meeting.
  - It was reported that more detail about STWs was observed at other organisations.

Action: KD to update the Committee more formally in relation to risk management activity and staffing within the Trust. Paper to be presented at the June 2021 meeting.

Action: DMc to seek assurance that the STW process was being following and that follow-up with management was taking place. Report to be made to the June 2021 meeting.

DISCUSSION ITEMS

5. Governance Pack	**AR (05/21) 003**

DMc reported that the overall position had improved in 2021 from a working capital perspective.

There had been 98 salary overpayments, although numbers in recent months had fallen. Budget Managers had been reminded of the importance of nominal roll oversight.

ML raised the importance of an up-to-date contracts register which could give an early warning of a tender rolling over. DMc advised that the contracts register had been implemented. Around 80% of the Trust's expenditure had been covered by the register. DMc expressed the view that part of the driver of the STWs was Trust reliance on one supplier.

LW queried how overpayments would be recouped by the Trust. DMc explained that legally, the Trust was entitled to recoup it straight away however, the Trust was keen not to cause distress to individuals.

Budget managers were expected to check their nominal roll for accuracy. Education was required to help colleagues read their payslips as part of personal responsibility in this area. Line managers were also expected to have face to face meetings to understand how an overpayment had happened and agree a reasonable repayment plan that does not cause financial hardship.

However, a firm line was taken with individuals who had left the organisation. Sums were sometimes written off in some legal recovery processes.

DMc stated that 6 people out of 7,500 people had been overpaid in March 2021, however, DMC acknowledged there were actions that needed to be put in place to reduce numbers, recognising that this sample would equate to more than 100 people per year.

6. Information governance/DSPT progress update and risks	**AR (05/21) 004**

KD reported that data security progress had been made since February 2021. She reported that the Trust's IG Manager had left the organisation leaving a vacancy, but external help from an agency consultant had proved highly successful.

The decision had been made to explore outsourcing IG, and a formal tendering process would be undertaken with three companies.

KD referred Committee members to the list of mandated requirements in the paper – compliance would be achieved in time for the end of June 2021 external submission. The majority of areas were 'green' and checks were being carried out to gather back-up evidence. There were a number of remaining 'reds' requiring attention.

The Information Governance Group had been reconstituted, which included the Medical Director and the Chief Informatics Officer. KD expressed the view that it would be a challenge to improve the 'amber' and 'red' rated items before June 2021, but there was reasonable confidence that it could be done.

SR reported that a lot of work had been done in relation to IT and security. The Trust was currently being audited by RSM and all the evidence was being currently uploaded. She reported that engagement with action-owners had been good.

KD reported that the Trust's mandatory training rate was currently 92% against a target of 95%. Around 800 staff across the organisation needed to complete mandatory training (the data protection module). Medicine and Surgery groups had the most staff outstanding.

LW expressed the view that reconvening the oversight group would make a big difference to progress.

7. Data quality progress update	**Verbal**

DB referred Committee members to the paper. He reported that good progress had been made on the data quality dashboard, with the Trust now being ahead of the national average.

Data quality log:

DB reported there had been 69 items in the log, of which seven were now closed. There were two new items which had not yet been allocated.

The Trust was currently trying to treat 34 items. DB reported that a further five were likely to be closed in the next month because they were either reporting or IT issues. The bulk of the challenge with data quality was the frontline operational issue. Of the 69, 48 were linked to operational and clinical.

DB further reported that the challenge would be to address the 19 prioritised items. LW requested that DB produce a one-page summary in relation to the data quality log for presentation to the June 2021 meeting.

Action: DB to produce a one-page summary with respect to the data quality log, for presentation to the June 2022 meeting.

8. SBAF update on progress	**AR (05/21) 005**

AH reported there had been some progress noted in the SBAF audit, however, it was reported that two thirds of the actions had not been closed off.

Three of the four outstanding actions related to the Safeguard system. He acknowledged that the Trust had employed an external advisor to make better use of the system, with work expected to be completed in June 2021.

In one case, the action had not been fully completed and related to the presentation of the SBAF in full to the Trust Board which was due in May 2021. KD reported this had been deferred until the June 2021 Board meeting.

LW commented that the Board had held a Board development session in February 2021 around risk and had seen the SBAF. However, it was hoped that in June 2021, a new SBAF linked to the new strategic objectives would be seen.

KD confirmed that the full SBAF would be taken to the next Board meeting.

Later in the meeting, KD reported that the SBAF for 2018/20 continued to be updated and presented to the relevant Board Committees. The update included progress against management actions, the risk scores and assurance levels.

KD reminded the Committee that some of the risks could come off the list for the Committee's attention because they had been successfully mitigated to a high confidence level.

9. 2021/22 Clinical Audit Plan	**AR (05/21) 006**

KD reported that clinical groups had been very ambitious and had submitted a lot of clinical audit plans. Some were nationally mandated and had to be included in the Trust's annual Quality Account (57).

There had been around 97 local priorities identified in addition, comprising of Trust, Group and clinician priorities.

KD explained that clinical audits offered assurance that procedures were in line with best practice or that things were working as they should.

LW queried where the learnings were shared from the outputs of the clinical audits. KD responded this was mostly done through the quality improvement half day sessions and annual poster competition but KD acknowledged there was still more to do.

ML suggested a good method of prioritising audits would be to consider which would contribute to the CQC process. KD and LW agreed this was a good idea to progress.

10. Annual accounts	**AR (05/21) 007**

DMc reported that the financial performance against the annual control total was £383k which had

been reflected in the accounts.

She reported that the Trust had met all of its key financial duties and the accounts also included the financial impact of the centrally procured equipment for the COVID-19 response and also PPE with a cost-neutral impact.

DMc expressed the view that the accounts had been more straightforward than previous years because of the circumstances. She stated that all guidance had been followed.

It was acknowledged that it had been a considerable achievement to get the accounts ready in difficult circumstances.

EXTERNAL AUDIT	
11. External Audit progress report, including annual reporting and significant risks	**AR (05/21) 008**

MS introduced the Audit Plan for the current year. He commented that it had been a strange period financially for the Trust because of the extra NHS funding arrangements, but he reminded the Committee that at some point the organisation would return to its more regular finance regime.

The value for money approach had also changed during the year.

In relation to risks MS commented that in terms of income, block funding should be easy to audit but income requiring matching against COVID-19 expenditure would need to be treated as a significant risk.

One of the standard risks required by monitoring standards concerned management override of control.

MS reported that as a result, there would be a lot of testing around payables, accruals, and estimates.

A significant estimate within the Trust's accounts was property, plant, and equipment and therefore, a lot of work would be undertaken to scrutinise the valuation.

Assets under construction was £467m – a value held at cost and MS commented that work would be done in terms of considering impairments. MMUH would be considered in this context.

Senior Officer remuneration had been reviewed. Expenditure, non-pay and unpaid payables would be looked at in detail to make sure to ensure a match with income claimed.

MS advised that the going concern definition had changed and now assumed that all public sector bodies were going concerns, unless dissolution had been decided. Disclosures and whether there should be an enhanced disclosure, would be reviewed with the Trust's finance team.

In relation to disputed balances in the previous year's audit, DMc stated that NHSE/I had advised the Trust to clear out any disputed balances in the retrospective top-up and therefore, no formal resolution process had been required.

There were three areas of sustainability focus:

- Financial sustainability
- Financial governance
- Improving economy, efficiency and effectiveness

MS reported that the team would report back findings in June 2021.

DMc commented that there was no system-wide sustainability in the Plan and queried how the Trust could provide assurance in this area. MS commented that it was hoped that triangulation could be possible, utilising other sources of information and audits.

LW expressed appreciation for the progress in terms of finance this year.

INTERNAL AUDIT	
12. Internal Audit Progress Report	**AR (05/21) 009**

AH referred Committee members to the paper. He explained that three reports had been finalised since the last meeting as follows:

- Human Tissue Authority Review
- General Ledger and Financial Reporting
- Payroll and Expenses

AH further reported that in addition, two further reports had been issued in draft:

- Data Quality Review
- SBAF Audit follow-up

Work had also commenced on:

- Data Security Protection Toolkit
- Wellbeing and Occupational Health Assessment Framework
- MMUH Contract Governance (Balfour Beatty)

AH assured the Committee that these would be forwarded as soon as possible.

Internal audit management actions had also been tracked and AH reported 71 actions that were overdue (6 high, 34 medium, 29 low and 2 advisory). AH advised that executive directors had been sent their respective actions for them to respond to.

The headline findings were:

Human Tissue Authority Review:

AH reported that the review had focused on compliance. He clarified that this review had been requested by the Trust and had been undertaken every few years.

Overall, a partial assurance opinion had been concluded. This was a negative opinion because certain areas concerning standard operating procedures required tightening-up, including specific induction training, the patient programme and contracts with suppliers, around human tissue.

There was a requirement for the team to have an audit plan including a regular audit schedule. Some of the sampling had identified issues in relation to the tracking and completeness of forms in relation to the suppliers of tissue.

AH advised that the majority of the actions should have been completed by the end of March 2021.

LW commented that the owners of the overdue actions needed to be held to account but observed that ownership of some of the broad range of actions was uncertain, which might be contributing to the delay.

KD reported that all overdue actions would be reviewed by the Performance Management Committee, chaired by the Trust Chief Executive, starting from May 2021.

General Ledger and Financial Reporting:

AH reported that there was an overall 'reasonable' assurance which was a positive opinion. Areas requiring medium priority action were:

Two medium priority actions had been identified – one concerning the accuracy of closing balances and the other concerning inappropriate user access to Oracle being removed in a timely manner through weekly reviews.

Some low priority actions had been identified in relation to budget requirements.

DMc commented that some of the outstanding actions had been resolved since the report was produced. CH reported that the trial balance issues were due to a system error which had been quickly identified and rectified. Checks had been made to ensure no internal or external reporting had been impacted and measures had been put in place to carry out daily checks.

A weekly process had been put in place to ensure there was no inappropriate access to key systems. DMC and CH agreed to supply an update to AH regarding the outstanding actions.

Payroll and Expenses:

AH reported that this had been impacted by COVID-19 and had slipped downwards to a 'partial' assurance level. The medium priority actions identified related to:

- The timely submission of leaver forms and changes which had led to overpayments. In six cases it had led to an underpayment.
- A requirement to update the authorised signature list.

Overall, AH commented that the key issue was the need to emphasis the timely completion and submission of employment termination forms.

DMc commented that she would like to see more joined up action between the Payroll and People & OD teams. DMc further commented that staff changes had delayed an updated authorised signature list but agreed this was a medium category priority which would be addressed.

ML expressed disappointment that there had been medium priority actions from last time in relation to the report which had not been implemented.

Data Quality Report (Draft):

AH explained that the Data Quality Report was a follow up of previously agreed management actions following the Kitemarking exercise and the WHO Safer Surgery.

AH reported that of 44 actions tracked, there had been 27 responses - 17 had been implemented and successfully closed, four partly implemented, one not implemented and five had been superseded.

AH commented that there would need to be more work in relation to the Safer Surgery checklist which had been previously identified as not being sufficiently robust. A working group had been established but its work had been impacted by COVID-19. AH commented that the group needed to continue to identify all of the invasive procedures to ensure a comprehensive list of areas requiring data collection.

Standardisation of the checklists needed to be implemented. AH commented that part of the remit of the oversight group was to ensure realistic delivery targets.

DB commented that the data quality issues were already known. He explained that those linked to frontline processes had stalled because of COVID-19. LW expressed sympathy but stressed that processes needed to be correctly followed despite the pandemic pressures.

Action: KD to ensure the list of 71 overdue management actions be taken to the Performance Management Committee in May 2021.

Action: DMc and CH to ensure that AH is updated with respect to outstanding management actions.

13. Annual Report and draft Head of Internal Audit Opinion 2021/21	**AR (05/21) 010**

MG reported that the formal Head of Internal Audit [draft] opinion was that the Trust had an adequate and effective framework for risk management, governance and internal control; however, there were a number of further enhancements required to ensure the situation remained so.

MG further advised that the standard second Partner review of information in the audit opinion process had raised some challenges to his opinion and queried whether it should be downgraded. However, it had been noted that some of the areas of concern had already been addressed.

In summary therefore, MG reported that the Trust was at the lower end of a positive opinion and suggested that the individuals responsible for the actions get a better grip on making improvements.

ML queried what the Trust needed to do to ensure it could maintain a positive opinion. MG suggested progress on the DSP Toolkit would be helpful but also stated there were no 'red' opinions before the end of the year.

ML queried how confident the Trust was in putting the DSP Toolkit into positive territory. KD reported this would be discussed later in the agenda.

KT queried whether the small size of the Trust's governance team was an issue. MG acknowledged this point and observed there had been a turnover of staff in KD's team. Absences in senior leadership had probably been a contributing factor.

LW stressed that it would be critical that the PMC ensured that the executive team was driving improvements.

MG commented that for context, most organisations for which he had given an opinion this year had fallen into the 'green/amber' second category.

14. Internal Audit Plan 2021/22 and Strategy 2021/22 – 2024/25	**AR (05/21) 011**

AH referred Committee members to the paper and highlighted that the Internal Audit Plan 2021/22 would include a number of risk-based assurance reviews covering the following topics:

- Safeguarding
- Infection Prevention and Control
- Annual Leave (Data quality)
- Freedom to Speak Up
- Vaccination programme (Data quality)

- Workforce (Pre-Employment Checks)
- Mental Health and Wellbeing
- Single Tender Waivers (STWs)
- Governance and Committee Effectiveness
- Procurement
- Harm reviews – clinical prioritisation and stratification

AH commented that the focus would be on testing the accuracy and robustness of the systems and assurances.

HK queried the focus of the review of the vaccination programme because there was likely to be another round of inoculations. AH assured the Committee that the timing of this review would be carefully considered to take this into account.

ML suggested the inclusion of a review of rostering to the Audit Plan to give the Trust fresh information as it moved to a new rostering software system. AH agreed that this could be added, making the point that it would be valuable for the Trust to regularly review the Plan to remain nimble and responsive to change.

MH queried the timing and the prioritisation of the associated activities. AH stated that all the timings were currently indicative.

DB expressed the view that reports should only be requested where they linked to key organisational risks to keep numbers manageable, otherwise there was a risk that the list of outstanding actions would increase. MG commented that the number of reviews requested were currently commensurate with similarly sized organisations.

SS queried the number of days on which the Audit Plan was based. AH responded that it was based on 400 days.

In response to a query from LW, MG stated that not all reviews needed to be done in 2021/22. LW stated that the timings of the audits needed to take benefit to the Trust into account.

KD to discuss with Executive Director colleagues potential inclusion of topics discussed, such as rostering and then discuss further with RSM.

Action: Discuss potential additional topics for the Internal Audit Plan 2021/22

15. Counter Fraud 2021/22 work plan	**AR (05/21) 012**

BV reported that the Government's functional standards had been used for reporting. In terms of added value, work was ongoing which would lead to benchmarking reports and reactive referrals.

A dummy invoice containing fictitious information would be introduced into the Trust with the agreement of DMc. It was hoped that this would get quicky identified and rejected. However, some benchmarking data would be produced to give the Trust an idea of its position in relation to this type of risk.

Another report would be produced towards the end of the year on STW usage.

BV referred Committee members to the fraud risks in the paper.

The workplan for the year was similar to previous years. Two pieces of work would be undertaken

proactively – pre-employment checks in Q1 and staff oversight and governance in Q3. A longer-term counter-fraud strategy (2021-2024) had been put in place.

OTHER MATTERS

16. Matters to raise to the Trust Board	**Verbal**

The following matters would be brought to the Trust Board:

- More drive to complete the management performance actions through the PMC.
- SBAF.
- The Head of Internal Audit opinion.
- The Annual Accounts process and external annual reporting.

17. Any Other Business	**Verbal**

- **The Chair requested that external members leave the meeting to allow a sensitive topic to be discussed.**

Contract arrangements for internal and external audit

DMc referred Committee members to the briefing note recommendations concerning internal and external audit services which required approval.

KD is the Executive lead for Internal Audit. RSM have been utilised for some time for internal audit and accountable services. DMc advised that this was currently a rolling contract on a 12-month basis. The current arrangement expired on the 31st of March and one of the options would be to retender with a start date of 1st April.

Benchmarking with Black Country colleagues had revealed that there was a large variation in audit days with the Trust's 400 days being at the higher end of the spectrum. DMc suggested a rescope to ensure value for money.

In terms of external audit, DMc expressed the view that the market was currently in a very unusual position, with many NHS Trusts finding it difficult to appoint an external auditor because few of the big providers were keen to provide services to the public sector.

GT had indicated that it could not make the timetable for the audit of Charitable Funds this year and therefore, using a more local provider might be an option to explore.

ML commented that the timing for a review might not be right given the demands of CQC pressure. LW stated that the Trust needed to be clearer on the rationale for some of the internal audits.

Date and time of next meeting: Thursday 17th June 2021, 09:00 – 10:30 via WebEx.

Signed ……

Print ……

Date ……